Claims Clues

A Publication of the AHCCCS Claims Department February, 2003

Superior Court Orders AHCCCS to Change Reimbursement for I/P Pathology Services

On January 13, 2003, the Superior Court of Arizona for Maricopa County ordered the agency to notify providers of the court's decision in Arizona Society of Pathologists v. AHCCCS.

The court mandated changes in the manner in which AHCCCS reimburses pathologists for the professional component of services rendered in a hospital setting. The text of the court order is attached to this issue of *Claims Clues*. ❒

Critical Access Hospital Bill Type Clarified

Chapter 11 of the *AHCCCS Fee-For-Service Provider Manual* has been updated to clarify the bill type to be used for services provided by critical access hospitals (CAHs).

In the "Billing Outpatient Hospital Services" section on Page 11-19, the sentence regarding outpatient hospital bill types has been revised to read:

"Bill Type must be 13X (appropriate third digit as listed in UB-92 manual), or ***85X*** for Critical Access Hospitals."

The change has been made to the on-line version of the *AHCCCS Fee-For-Service Provider Manual*, available on the AHCCCS Web site at www.ahcccs.state.az.us. Providers who have a paper copy of the manual should note this change.

There currently are five CAH hospitals in Arizona: Benson Hospital, Northern Cochise Community Hospital, Page Hospital, Southeast Arizona Medical Center, and Wickenburg Regional Medical Center. ❒

Forms Allow Providers to Fix Claims, Check Status

The *AHCCCS Fee-For-Service Provider Manual* contains two forms that providers may use to check the status of claims and to make changes to claims.

The Claim Correction Request Form and the Claim Status Request Form are available at the end of Chapter 26 of the manual.

Use of the forms is one of three options available to providers. Providers may check claim status by contacting the Claims Customer Service Unit. Providers also may check claim status on the AHCCCS Web site at www.ahcccs.state.az.us.

The Customer Service Unit has been experiencing a high volume of telephone calls, and inquiries are limited to three claims per call.

The Claim Status Request Form and the Claim Correction Request Form must be faxed to the AHCCCS Claims Research/ Adjudication Unit at (602) 253-5472.

Providers who wish to check on the status of a claim should wait 21 days after submission of the claim before contacting the Customer Service Unit or submitting the Claim Status Request Form. This will allow time for the claim to be imaged, entered into the AHCCCS Claims System, and processed by the system.

(Continued on Page 2)

Interested in provider training? Please complete the attached form.

Forms Allow Providers to Fix Claims, Check Status

(Continued from Page 1)

The following changes may be made using the Claim Correction Request Form:

- Enter Medicare amounts (EOMB must be attached)
- Change, add, or delete a procedure modifier
- Change, add, or delete diagnosis and revenue codes
- Change or delete procedure and NDC codes
- Change number of units
- Change or add bill type, admit date, type, source, discharge hour, patient status, coinsurance days, and date of service
- Change, add, or delete occurrence codes and dates
- Change, add, or delete condition codes
- Change dates of service
- Change or add place of service code

Please use a separate sheet for each provider. However, providers may submit as many sheets as needed. ❒

Manual Updated to Indicate Modifier 80 Reimbursement

Chapter 10 of the *AHCCCS Fee-For-Service Provider Manual* has been updated to indicate the reimbursement when a surgical procedure is billed with Modifier 80 (Assistant surgeon).

Under "Surgeon Billing" on Page 10-27, the section that discusses the use of modifiers when multiple surgeons participate in a surgery has been revised to read:

"80 Assistant surgeon (reimbursed at 20 percent of the capped fee or billed charges, whichever is less)"

The change has been made to the on-line version of the manual, available on the AHCCCS Web site at www.ahcccs.state.az.us. Providers who have a paper copy of the manual should note this change. ❒

Fee-For-Service Provider Training Considered

The AHCCCS Claims Department is considering conducting training session for fee-for-service providers beginning in late May.

Contingent upon provider interest, training sessions will be conducted in Phoenix and ***may*** also be conducted in Flagstaff and Tucson.

The training sessions are designed to provide a forum whereby AHCCCS can disseminate general fee-for-service billing information to providers. The sessions also will allow providers to discuss issues with AHCCCS Claims staff. It is anticipated that these meetings will last 2½ to 3hours.

If you are interested in participating in one of these training sessions, please complete the form attached to this issue of Claims Clues and submit it to the AHCCCS Claims Policy/Training Unit by March 15, 2003. ❒

Use of 1-800 Telephone Numbers Restricted

Claims Customer Service and certain other AHCCCS Units no longer accept calls to the 1-800 phone numbers from providers in the Phoenix metro area.

The restrictions apply to Phoenix metro area providers whose telephone area code is 602, 480, or 623.

Providers in the Phoenix metro area must call (602) 417-7670 (Option 4) to contact Claims Customer Service. Providers *outside* the Phoenix metro area may call toll-free at 1-800-794-6862.

The restriction on accepting the 1-800 numbers applies to other agency phone numbers frequently called by providers:

AHCCCS Verification Unit: Phoenix area providers must call (602) 417-7000. All others should call 1-800-962-6690

Interactive Voice Response (IVR): Phoenix area providers must call (602) 417-7200. All others should call 1-800-331-5090.

When callers from within Maricopa County dial the agency's 1-800 phone numbers instead of dialing the local area code numbers, it costs the agency thousands of dollars each month. The change will result in a savings to the agency of approximately $5,000 per month. ❒

Text of Court Order Regarding Reimbursement for Inpatient Pathology Services

On June 1, 1999, the AHCCCS Administration published the following Policy Statement in "Claims Clues," the agency's newsletter:

> In accordance with Medicare guidelines, physicians may bill only a limited number of CPT Codes for pathology services performed in a hospital setting. AHCCCS follows Medicare Guidelines and will only pay physicians and other individual practitioners for the medical interpretation of a pathology test performed at a hospital. AHCCCS does not reimburse physicians for the technical portion of tests performed at a hospital or for any indirect costs, such as supervising the laboratory.

This policy is also contained in the AHCCCS Fee-For-Service Provider Manual.

On March 7, 2000, the Governor's Regulatory Review Council issued a decision that this AHCCCS Policy Statement is an invalid rule. AHCCCS, however, continued to enforce this policy under its interpretation of A.R.S. §36-2918, a statute that prohibits claims for services that are not provided as claimed. AHCCCS contended that pathologists' claims for "hands off" or indirect services, such as medical direction and supervision of the hospital laboratory, do not constitute professional services provided as claimed.

The Arizona Society of Pathologists sued the AHCCCS Administration and Phyllis Biedess to enforce the Decision of the Governor's Regulatory Review Council.

Following a decision by the Arizona Court of Appeals, the Superior Court in Maricopa County entered Final Judgment on October 9, 2002, in favor of the Arizona Society of Pathologists. The terms of the Final Judgment, with which AHCCCS ***must*** fully comply, are:

IT IS HEREBY ORDERED that this Policy Statement, and any related agency policies and practices in implementation thereof, are illegal and unenforceable by defendants in any manner whatsoever.

IT IS FURTHER ORDERED that plaintiffs' practice of billing for indirect services (or "professional component billing") whereby pathologists bill a nominal fixed fee for each laboratory test, regardless of the amount of time a pathologist devotes to a particular test, is an appropriate billing practice, coverage of which is not prohibited by A.R.S. §36-2918.

IT IS FURTHER ORDERED that defendants shall pay pathologists for properly submitted claims for such indirect pathology services unless and until such time that the agency properly promulgates a rule barring such coverage, or the agency identifies an existing statute or rule that specifically disallows coverage for such services.

IT IS FURTHER ORDERED that defendants shall amend forthwith all agency publications, policies, and practices that are inconsistent with this Final Judgment, to conform with this Final Judgment.

IT IS FURTHER ORDERED that defendants shall not deny any pathologists' claims for indirect services on the basis of the timeliness of submitting such claims, for any claims from June 1, 1999 to the present, provided such claims are submitted within six (6) months from the date of entry of this Final Judgment.

On January 13, 2003, the Court further ordered that AHCCCS ***must*** demonstrate full compliance with the terms of the Final Judgment no later than February 10, 2003, which compliance must include at least the following:

- All necessary revisions to all agency provider manuals, newsletters, claims edits and fee schedules.
- Publication of this notice. Pathologists may submit claims from past years as well as for ongoing services, and pathologists may submit claims for past services within six months from the date on which this Court determines that the defendants are in full compliance with the Final Judgment.

Providers are hereby notified that pathologists may submit their claims for the professional component of clinical laboratory services, and AHCCCS must process these claims consistent with the terms of the Final Judgment. This includes claims for such "hands-off" or indirect services as were in dispute. This also includes claims from previous years, as well as for ongoing services.

AHCCCS Provider Training Survey

The AHCCCS Claims Department is considering conducting training session for fee-for-service providers beginning in late May. Contingent upon provider interest, sessions will be conducted in Phoenix and ***may*** be conducted in Flagstaff and Tucson.

The training sessions are designed to provide a forum whereby AHCCCS can disseminate general fee-for-service billing information to providers. The sessions also will allow providers to discuss issues with AHCCCS Claims staff. It is anticipated that these meetings will last 2½ to 3hours.

If you are interested in participating in one of these training sessions, please complete the form below and fax it to the AHCCCS Claims Policy/Training Unit at (602) 256-1474. You also may mail this form to:

AHCCCS Claims Policy/Training Unit
701 E. Jefferson Street, MD 8100
Phoenix, AZ 85034

Please return this form no later than March 15, 2003. Thank you.

Provider Name: _____

Provider Type:
(e.g., physician, hospital, emergency transportation, etc.) _____ AHCCCS Provider ID: _____

Street Address or P.O. Box: _____

City: _____ State: _____ ZIP: _____

Contact Person: _____ Telephone: ( ) _____

E-mail: _____ FAX: ( ) _____

Suggested topics: _____

_____

_____

_____

_____

I would prefer to attend a training session in (Please indicate first, second, and third choice):

Phoenix _____ Tucson _____ Flagstaff _____